

## PSYCHOLOGICAL OUTCOMES AMONG LESBIAN SEXUAL ASSAULT SURVIVORS: AN EXAMINATION OF THE ROLES OF INTERNALIZED HOMOPHOBIA AND EXPERIENTIAL AVOIDANCE

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This study explored the relations among internalized homophobia (IH), experiential avoidance, and psychological symptom severity in a community sample of 72 lesbian sexual assault survivors. Results indicated that IH is associated with both experiential avoidance and posttraumatic stress disorder (PTSD) symptom severity. In addition, experiential avoidance is related to both PTSD and depression symptom severity. Finally, experiential avoidance completely mediated the relation between IH and PTSD symptom severity. The implications of these findings are discussed and suggestions for future research are provided.

Lesbian sexual assault survivors have received relatively little attention in the literature (Hughes, Johnson, & Wilsnack, 2001). This is surprising, because there are several compelling reasons to study this population. Epidemiological research suggests that 18–22% of lesbians report having experienced childhood sexual abuse (CSA) and that 21–40% report having experienced adult sexual assault (ASA; Balsam, Rothblum, & Beauchaine, 2005; Heidt, Marx, & Gold, 2005). These rates are somewhat comparable to those of heterosexual women, whose CSA rates range from 11 to 32% (Balsam et al., 2005; Briere & Elliott, 2003) and ASA rates range from 12 to 22% (Balsam et al., 2005; Elliott, Mok, & Briere, 2004).<sup>1</sup> Although ex-

periencing a trauma does not always lead to the development of posttraumatic stress disorder (PTSD), sexual assault results in higher rates of PTSD relative to other traumatic experiences (e.g., physical assault, robbery with weapon; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Norris, 1992). Furthermore, regardless of the type of traumatic exposure, women consistently develop PTSD and other negative trauma sequelae at higher rates than men (Simmons & Granvold, 2005; Tolin & Foa, 2002). Given the high sexual assault rates reported by lesbians, the pathogenic influence of sexual assault, and their likely vulnerability to PTSD based upon their gender, it is important to research the factors that influence lesbians' recovery from sexual assault, particularly those that could influence treatment recommendations.

To this point, researchers have neglected to examine sociocultural factors that may influence lesbian sexual assault survivors' psychological outcomes. One such culturally relevant factor is internalized homophobia (IH).<sup>2</sup> IH stems from the acceptance of negative stereotypes and myths about homosexuality that permeate mainstream culture and has been defined as "a set of negative attitudes and affects toward homosexuality in other persons and toward homosexual features in oneself" (Shidlo, 1994, p. 178). IH is important to study because it is a sociocultural phenomenon specific to sexual minorities that can account for variance that cannot be explained by other psychological phenomenon that apply to heterosexual individuals

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(Gonsiorek, 1982; Maylon, 1982). Among gay men and lesbians, IH is associated with depression (Herek, Gillis, Cogan, & Glunt, 1997; Igartua, Gill, & Montoro, 2003; Shidlo, 1994; Szymanski & Chung, 2001), substance use and alcohol consumption (DiPlacido, 1998; Meyer, 1995), somatic symptoms (Shidlo, 1987), unstable self-concept (Shidlo, 1987), demoralization (Herek et al., 1997), and low self-esteem (Herek et al., 1997).

Because some of the widespread homophobic myths are related to sexual assault, and IH is linked to believing such myths, IH may be particularly relevant to lesbian survivors. Specifically, these myths include the notion that sexual abuse causes homosexuality<sup>3</sup> (Balsam, 2003; Butke, 1995) and that LGBT (lesbian, gay, bisexual, and transgendered) individuals deserve to be sexually assaulted because they are immoral and deviant (Arey, 1995; Garnets, Herek, & Levy, 1990). Another component of IH stems from the fact that homosexuality used to be considered a mental illness by mental health professionals and thus was listed as a psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders* until 1973 (Davison & Neale, 1994). IH, therefore, may be connected with lesbian survivors viewing themselves as weak, crazy, and vulnerable to interpersonal traumas, such as sexual assault (Kantor, 1998). Although researchers have suggested that lesbian sexual assault survivors may have a more difficult recovery than heterosexual survivors due to the chronic stress associated with their minority status (Meyer, 1995; Hughes et al., 2001), no one has investigated the impact of IH on the symptom severity of lesbian survivors. Gold, Marx, and Lexington (2007), however, did explore the impact of IH on the recovery of gay male sexual assault survivors. They found that, in a community sample of 74 gay male survivors, IH was associated with both depressive and PTSD symptom severity. In addition, they found that experiential avoidance partially mediated the relation between IH and depressive and PTSD symptom severity.

In this study, we applied Gold et al.'s (2007) hypotheses to a lesbian sample of sexual assault survivors and investigated the relations among IH, experiential avoidance, and both PTSD and depression symptom severity. Depression and PTSD were chosen as outcomes for several reasons. First, researchers have consistently found that these two disorders are the most common sequelae to sexual assault in the general population (Kessler et al., 1995; Resick, 2001), and these findings have been extended specifically to lesbians (Heidt et al., 2005). Furthermore, epidemiological research suggests that PTSD often emerges subsequent to trauma and that depression, in turn, results from having PTSD (Kessler et al., 1995; Resick, 2001). As such, most trauma treatment outcome studies examine the influence of their interventions on both disorders (e.g., Foa et al., 1999; Tarrier et al., 1999). Depending on when in this sequence they seek treatment, lesbian sexual assault survivors may present with PTSD or PTSD and depression, and so it is important to explore the factors that may influence

one or both disorders. Several studies have already shown that IH is associated with depression among LGBT individuals (e.g., Lewis, Derlega, Griffin, & Krownski, 2006; Szymanski, Chung, & Balsam, 2001). The research on IH and PTSD, however, has been limited and inconsistent. Both Skinta (2007) and Gold and colleagues (2007) found that that IH and PTSD symptom severity were positively correlated. Alternatively, Rivers (2004) reported that traumatized sexual minorities with PTSD symptoms evidenced less IH than those without any PTSD. These disparate findings suggest that more research on the relations among IH, depression, and PTSD is warranted.

Our preliminary hypotheses were that both IH and experiential avoidance would be positively associated with PTSD and depression symptom severity among lesbian sexual assault survivors. As detailed above, the IH-based myths and stereotypes connecting sexual assault with one's sexual orientation are likely to cause lesbians to react to their sexual assault histories with shame, self-blame, helplessness, and guilt, all of which have been found to predict PTSD and depression in presumably heterosexual sexual assault survivors (Andrews, Brewin, Rose, & Kirk, 2000; Frazier, 1990; Kubany et al., 1995). In addition, the literature has consistently linked depressive symptoms with IH among sexual minorities regardless of their traumatic experiences (Herek et al., 1997; Igartua et al., 2003; Shidlo, 1994; Szymanski et al., 2001).

We also expected to replicate prior findings in the literature on the relation between experiential avoidance and trauma sequelae. Experiential avoidance has been previously defined as the unwillingness to remain in contact with aversive bodily sensations, emotions, thoughts, memories, and behavioral predispositions and includes taking steps to alter the form or frequency of those events and the contexts that occasion them (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Gold (2008) argued that it is particularly important to study experiential avoidance among trauma survivors because of its breadth. Trauma has been linked to various forms of avoidance, such as emotion suppression, emotion avoidance, substance abuse, thought suppression, emotional inexpressivity, and self-harm behavior (Marx & Sloan, 2002; Polusny & Follette, 1995). Experiential avoidance is a construct that subsumes a variety of avoidance mechanisms utilized by trauma survivors and therefore merits further investigation. Furthermore, researchers have connected experiential avoidance with several negative outcomes, including PTSD and depression, among presumably heterosexual female (Marx & Sloan, 2002, 2005; Polusny, Rosenthal, Aban, & Follette, 2004) and gay male sexual assault survivors (Gold et al., 2007). Polusny and Follette (1995) suggested that trauma survivors engage in experiential avoidance in response to sexual assault-related negative affect and that these avoidant strategies become negatively reinforced because they temporarily lead to symptom reduction. In the long run, however, this avoidance leads to diminished functioning and increased psychological

symptoms (Polusny & Follette, 1995). As such, we hypothesized that experiential avoidance would be associated with both depression and PTSD symptom severity among lesbian sexual assault survivors.

In addition, we hypothesized that experiential avoidance and IH would be associated with one another. Prior LGBT research has indicated that individuals with IH attempt to pass as heterosexual (Nungesser, 1983), socially isolate themselves (Herek et al., 1997; Nungesser, 1983; Szymanski et al., 2001), exhibit lower levels of sexual orientation disclosure (Herek et al., 1997; McGregor et al., 2001; Szymanski et al., 2001), and report sexual dysfunction (Rosser, Metz, Bockting, & Buroker, 1997). These behaviors are all consistent with the aforementioned definition of experiential avoidance. Therefore, it is possible that IH is related to lesbian survivors' avoidance of their attractions, emotions, and somatic reactions.

Finally, we tested a model based upon Foa and colleagues' emotional processing theory (e.g., Foa & Riggs, 1993; Foa & Rothbaum, 1998) that could explicate the associations among the variables explored in this study. Emotional processing theory explains individual differences in trauma recovery and predicts who will and will not go on to develop PTSD, which it conceptualizes as a form of pathological fear fueled by cognitive associations. Pathological fear, in turn, leads individuals to engage in escape and/or avoidance behaviors, which can lead to PTSD (Tolin & Foa, 2002). According to this theory, schemas play a significant role in the development of deleterious cognitive associations. Schemas have been defined as "relatively enduring internal structures of stored generic or prototypical features of stimuli, ideas, or experiences that are used to organize new information in a meaningful way thereby determining how phenomena are perceived and conceptualized" (Clark & Beck, 1999, p. 79). Schemas develop and are altered through life experiences, such as sexual-orientation-based discrimination, and go on to influence the cognitive processing of and behavioral responses to experiences. Schemas often lead to the distortion of memories and interpretations of the event in ways that are consistent with the schema. They also cause attentional bias toward evidence in support of the schema and threat and disregard contrary evidence. This attention and focus then triggers fear and responses of escape and avoidance consistent with PTSD. Trauma researchers emphasize the importance of both self and world schemas to the recovery of the survivor. Specifically, Foa and Rothbaum (1998) proposed that rigid beliefs that the world is unsafe and/or that the individual is incompetent and unable to protect herself make one particularly prone to PTSD.

IH, we propose, could be viewed as a sociocultural schema, a pathogenic lens through which lesbian sexual assault survivors view their traumatic experiences, which leads to fear and avoidance and the consequent development of PTSD symptoms. Based on the aforementioned myths, the IH schema could cause lesbian sexual assault sur-

vivors to view the world as unsafe. They could feel blameworthy (i.e., they deserve to be sexually assaulted) or view themselves as incompetent to protect themselves and heal (i.e., lesbianism is a mental illness). According to emotion-processing theory, these beliefs then lead to erroneous associations between stimuli (e.g., lesbianism connected with sexual assault), inaccurate and incomplete processing of the trauma, extensive fear and avoidance, and eventual PTSD symptoms (Tolin & Foa, 2002). Following this theory's trajectory, the schema of IH could lead to various forms of avoidance, including avoidance of one's own sexual desires and thoughts, avoidance of intimacy with others, and avoidance of emotional sequelae to the assault, such as fear and sadness. In turn, this avoidance would then prohibit processing the event, habituating to emotions, and the realization that certain stimuli (e.g., one's sexual orientation) are not connected with the trauma, thus predisposing the lesbian survivor to psychological symptoms. In other words, we hypothesized that experiential avoidance will mediate the relation between IH and PTSD symptom severity in lesbian sexual assault survivors.

In summary, we proposed four hypotheses specific to lesbian sexual assault survivors. First, we suggested that IH would be associated with both PTSD and depression symptom severity in this population. Second, we hypothesized that experiential avoidance would be related to both PTSD and depression symptom severity. Third, we proposed that experiential avoidance and IH would correlate with one another. Finally, we predicted that experiential avoidance would mediate the relation between IH and both depressive and PTSD symptom severity.

## METHOD

### *Participants*

Three-hundred forty-two adults who identified as sexual minorities were recruited from community organizations ( $n = 41$ ) and events ( $n = 301$ ) and asked to complete measures assessing IH, psychopathology, and life experiences. Some of these data were used in two other studies, including one that examined patterns of sexual trauma found in LGBT populations (see Heidt et al., 2005) and one that examined the impact of IH on gay male sexual assault survivors (see Gold et al., 2007). For this study, only those who identified as lesbians and endorsed one or more episodes of CSA or ASA were included. Bisexual and transgendered individuals were excluded due to difficulties in measuring their IH: No IH measures have been developed for bisexual or transgendered individuals. Because extant IH measures use language such as "As a lesbian, I am..." and test stereotypes specific to lesbians or gay men, we suspected that these measures would not validly assess IH in individuals with other identifications (Dillon, 2001). Gay men were excluded because their results have already been published in another study (see Gold et al., 2007). In total, 9

transgendered, 72 bisexual, 120 gay male, and 17 individuals who failed to identify a sexual orientation were excluded from the present study. Because several studies have already examined the impact of IH on lesbians in general (e.g., Igartua et al., 2003; Lewis, Derlega, Clarke, & Kuang, 2006; Szymanski et al., 2001), 52 lesbians who did not endorse sexual assault histories were also excluded. The final sample included 72 lesbian sexual assault survivors.

The age of the final sample ranged from 18 to 63 ( $M = 33.47$ ,  $SD = 11.78$ ). The ethnic composition was 67.1% Caucasian, 7.1% African American, 4.3% Hispanic, 1.4% Asian, 1.4% Native American, 4.3% Mixed, and 7.1% Other. Another 7.1% of the sample did not identify an ethnicity. Within this sample, 18 individuals (24.3%) reported experiencing both CSA and ASA, 27 individuals (37.1%) endorsed CSA only, and 27 (38.6%) endorsed ASA only. Participants received \$10 in return for their participation. Recruitment and testing were in accordance with the American Psychological Association's ethical guidelines regarding the use of human participants. The Institutional Review Board for a university in the northeastern United States approved the protocol and informed consent form.

### Measures

The following instruments were administered in an order that placed the more sensitive questionnaires (i.e., trauma history) at the end of the packet.

*Sexual trauma measures.* The Life Experiences Questionnaire–Modified (LEQ; Long, 1999) is a 62-item self-report measure about CSA. For purposes of this study, the LEQ was used to determine whether or not participants had experienced CSA, which was defined as contact abuse (e.g., nonpenetrative genital contact) and/or attempted or completed penetration prior to the age of 18 that was either perpetrated by a relative, by someone more than 5 years older than the survivor, or by someone less than 5 years older but who used threat or force to commit the abuse. The LEQ assesses various aspects of CSA, including the nature and severity of abuse, its duration, the survivor's relationship to the perpetrator, and whether or not disclosure occurred. It asks individuals to mark "yes" or "no" to a number of experiences that range in severity from non-contact exposure to completed intercourse. The LEQ furnishes information regarding specific aspects of CSA and does not provide an overall score. However, the information provided can be used to create a composite score of abuse severity, duration, and frequency. Messman-Moore and Long (2000) have shown that the LEQ displays adequate internal consistency (Cronbach alpha = .89) and 2-week test-retest reliability (kappa = .39 for severity of force; kappa = 1.0 for abuse duration). High interclass correlations have been reported for age of onset of abuse (.99) and age of perpetrator (.96). The validity of the LEQ has been supported in that participants' endorsements on the

measure have been found to correspond with their answers during structured clinical interviews regarding childhood maltreatment (Kaupie & Abramson, 1999).

The LEQ was modified for use in the current study such that the term "intercourse" was specified to include oral–genital contact and both anal and vaginal penetration by a body part or object. This clarification was necessary because the definition of intercourse may be less clear when asking about same-sex sexual activity because a mainstream definition of this term is often limited to penile–vaginal penetration only. This measure, along with the described modifications, has been used in two other studies examining CSA among lesbians, bisexuals, and gay men (see Gold et al., 2007; Heidt et al., 2005).

The Sexual Experiences Scale–Modified (SES–Adult Version; Koss, Gidycz, & Wisniewski, 1987), a 10-item (yes/no) self-report instrument, is an extensively used measure of ASA (Testa, VanZile-Tamsen, Livingston, & Koss, 2004). In the current study, the SES was used to determine the presence of unwanted adult sexual experiences reported by each participant. For purposes of this investigation, ASA was defined as nonconsensual genital contact, coerced sex, nonconsensual attempted penetration, and/or nonconsensual completed penetration occurring after the age of 18.

Similar to the LEQ, the measure does not create an interpretable overall score but does provide information that researchers may find useful about the characteristics and severity of the assault. Items assess degree of unwanted sexual experiences, including sex play, sexual coercion, attempted rape, and rape occurring after the age of 18. In an examination of the reliability and validity of the SES, Koss and Gidycz (1985) demonstrated moderately strong internal consistency for women and men (Cronbach alphas of .74 and .89, respectively) and strong 1-week test-retest reliability (.93). Further, the SES's validity was supported by a .73 correlation between self-reported trauma severity on the SES (nonvictimized, sexually coerced, sexually abused, and sexually assaulted) and severity reported during a face-to-face interview format (Koss & Gidycz, 1985). The SES's definition of penetration was also explicated on this form to include oral–genital contact and both anal and vaginal penetration by a body part or object for the same reasons described for the LEQ. This modified version of the SES has been used in two other studies examining ASA among lesbians, bisexuals, and gay men (see Gold et al., 2007 and Heidt et al., 2005).

*Psychological outcome measures.* The Lesbian Internalized Homophobia Scale (LIHS; Szymanski & Chung, 2003) is a 52-item, self-report measure designed to examine IH in lesbians. Items use a Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*), and 27 items are reverse scored to reduce response sets. The LIHS consists of five subscales that reflect dimensions thought to underlie IH in lesbians: connection with the lesbian community

(CLC), public identification as a lesbian (PIL), personal feelings about being a lesbian (PFL), moral and religious attitudes toward lesbianism (MRATL), and attitudes toward other lesbians (ATOL). Intersubscale correlations for the measure range from .37 to .57, indicating that the subscales are moderately correlated with one another, supporting the five subscales as distinct but correlated dimensions (Szymanski & Chung, 2003). The alpha for the total scale is .94, and correlations between the total and subscale scores range from .60 to .87. Construct validity of the LIHS has been demonstrated by significant correlations between the LIHS subscales and measures of self-esteem and loneliness. Finally, test-retest correlations for scores on the LIHS total scale and subscales were .93 (LIHS total scale), .91 (CLC), .93 (PIL), .88 (PFL), .75 (MRATL), and .87 (ATOL). Total scores are divided by the number of items. Overall scores range from 1 to 7, with 7 representing severe IH. The LIHS overall score was used in this study to measure IH in lesbian participants.

*Experiential avoidance.* The Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004) is a 9-item self-report measure of experiential avoidance. On the AAQ, respondents rate the degree to which each statement applies to them using a Likert-type scale ranging from 1 (*never true*) to 7 (*always true*). The measure is balanced for responding with half of the items requiring reverse scoring. The nine items offer key aspects of the experiential avoidance construct, including inaction, literalness of thought, controlling private events, and escape or avoidance of negatively evaluated content (Hayes et al., 2004). Respondents evaluate statements such as "When depressed or anxious, I am unable to take care of my responsibilities," "I'm not afraid of my feelings," and "Anxiety is bad." The possible range of scores on the AAQ is 9 to 63, with higher scores indicating greater experiential avoidance (Hayes et al., 2004). Because the AAQ is a relatively new measure, little has been published at this time regarding norms or score interpretation. However, the authors of this measure have found that the mean AAQ score for a combined group of clinical samples was 42, and the mean score for a combined group of nonclinical samples was 38 (Hayes et al., 2004).

The AAQ has been found to correlate moderately to highly with measures of general psychopathology, depression, anxiety, social phobia, anxiety sensitivity, and PTSD symptomatology (Hayes et al., 2004). Given that the AAQ has a small number of items, its internal consistency (Cronbach alpha) of .70 (Hayes et al., 2004) is considered adequate (Nunnally, 1978). It has demonstrated convergent validity ( $r = .44-.50$ ) with another measure of avoidant coping, the White Bear Suppression Inventory (Wegner, 1994). It has been used to assess experiential avoidance among sexual assault survivors in several other studies (e.g., Marx & Sloan, 2002, 2005; Polusny et al., 2004) and has been applied to gay males in one study (Gold et al., 2007).

*Depression.* The Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996) is a 21-item self-report scale that assesses the behavioral, affective, cognitive, and psychological components of depression. The BDI-II is the most frequently used self-report measure of depression (Beck et al., 1996). Each item is rated on a 4-point scale, and the overall score is a measure of severity of depression. Scores of 5–9 are not indicative of depression, 10–18 suggest mild to moderate levels, 19–29 suggest moderate to severe depression, and 30–63 suggest severe depression (Beck et al., 1996). The authors also proposed that scores below 4 suggest denial of symptoms, or faking good, and scores above 40 may indicate exaggeration. The BDI-II has an internal consistency coefficient of .91, test-retest-reliability coefficient of .93, and demonstrates convergent validity with the Hamilton Psychiatric Rating Scale for Depression ( $r = .71$ ; Beck et al., 1996). It consistently significantly correlates ( $r = .60-.90$ ) with clinical ratings of depression (Shaver & Brennan, 1991) and has been used previously in research with sexual minorities (e.g., Lee, Cohen, Hadley, & Goodwin, 1999) and sexual assault survivors (e.g., Alvarez-Conrad, Zoellner, & Foa, 2001). The BDI-II was used in this study as a measure of depressive symptom severity.

*PTSD symptomology.* The Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997) is a 49-item, self-report questionnaire that assesses the presence and severity of PTSD symptoms, as designated by the American Psychiatric Association's fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (1994). Foa et al. (1997) demonstrated the internal consistency of the PDS: It had a coefficient alpha of .92 for the total PDS severity score when utilized in diagnosing PTSD. Strong 2-week test-retest reliability has been shown for both symptom severity and PTSD diagnoses obtained via the PDS (.74; Foa et al., 1997). The PTSD diagnosis obtained through the PDS has been compared with diagnoses obtained through the SCID-PTSD module (Spitzer, Williams, Gibbon, & First, 1990). With a kappa of .65 and 82% agreement between the two measures, its validity has been shown to be adequate (Foa et al., 1997). The PDS has been used in various studies as a measure of PTSD symptomatology among sexual assault survivors (e.g., Halligan, Michael, Clark, & Ehlers, 2003) and several other studies with sexual minorities (e.g., Dillon, 2001; Gold et al., 2007; Heidt et al., 2005). Overall PDS scores of 0–10 indicate mild symptomatology, 11–20 suggest moderate severity, 21–35 indicate moderate to severe severity, and scores of 36 and above are in the severe range (Foa, 1995). This study used the PDS overall score as a measure of PTSD symptom severity.

### Procedure

Recruitment occurred at LGBT community events (two gay pride festivals in two cities in the northeastern United

States) and LGBT organization meetings (e.g., meetings at a community LGBT center; an LGBT student organization at a small, private liberal arts college; and an LGBT student organization at a large public university). Coordinators of the meetings and events were contacted and provided with information about the purpose of the study and its procedures. They were informed that the experimenters were examining stressful life events and emotion in the LGBT communities, including past and present sexual experiences. They were provided with copies of all of the questionnaires, the planned procedures, confidentiality policies, and consent forms. If coordinators chose to participate, they signed a letter confirming that they had granted the experimenters permission to invite members of their group or event to take part in the study. The coordinators decided on the appropriate time and place for data collection.

When participants were recruited during LGBT organization meetings, graduate student research assistants made announcements either immediately before or after the meeting inviting those present to participate in a psychological study about LGBT individuals. They explained that the research included questions about life experiences, including those that were sexual in nature, and emotional reactions. Individuals who expressed interest were invited to remain after the meeting to complete the questionnaires. They were seated far enough apart to allow for privacy.

During community event recruitment, two trained graduate research assistants sat at a booth with a sign inviting them to participate in research. Those that approached the booth were told that the study was about stressful life events, including past and present sexual experiences, and emotional reactions within the LGBT communities. To prevent having too many individuals complete the measures at any given time, all willing individuals were asked to schedule an appointment throughout the day when they could complete the questionnaires. During their scheduled appointments, small groups (no larger than 10) of individuals completed the questionnaires at a table with chairs spread far enough apart to allow for privacy. The research assistants remained in the vicinity to answer any questions.

Whether they were recruited from LGBT organizations or the community events, all individuals were informed that participation involved spending about an hour completing a battery of questionnaires and that they would receive \$10 compensation. All participants signed informed consent forms that included information on the purposes of the study and confidentiality of their responses before completing the questionnaires. No participant declined to participate after reading the informed consent, nor did any participant terminate prior to completing the packet.

Upon completing the questionnaires, participants were provided with a debriefing form that stated the purpose of the study and provided referrals to LGBT-friendly psychological service agencies. Further, the form encouraged

participants to discuss strong reactions or discomfort resulting from filling out the questionnaires with the experimenters if they felt comfortable doing so. Phone numbers and e-mail addresses for the experimenters were provided in case participants felt more comfortable communicating about their experiences at a later time or were interested in learning about the results of the study.

## RESULTS

### *Preliminary Analyses of the Sample*

Participants recruited from community events were compared to those recruited from LGBT organizations. No significant differences between these groups were found for the sexual trauma category,  $\chi^2 = (2, N = 72) = 2.96, p > .05$ , or ethnicity,<sup>4</sup>  $\chi^2 = (3, N = 72) = 1.47, p > .05$ . The organization recruitment group, however, was significantly younger ( $M = 22.83, SD = 3.43$ ) than the community recruitment group ( $M = 34.5, SD = 11.8$ ),  $F(1, 67) = 5.754, p < .05$ . This difference is to be expected given that the organization recruitment group was recruited at university-based LGBT organizations. With respect to psychological outcomes, the recruitment groups did not differ in any category, including depressive symptom severity,  $F(1, 66) = .04, p > .05$ ; experiential avoidance,  $F(1, 68) = .15, p > .05$ ; PTSD symptom severity,  $F(1, 67) = .4, p > .05$ ; and IH,  $F(1, 62) = .07, p > .05$ .

Psychological outcomes were explored by ethnic identity. Ethnicity groupings did not differ from one another on experiential avoidance, IH, or PTSD symptom severity. Tukey's Honestly Significant Difference (HSD) analyses, however, indicated that those who identified as Mixed ethnicity endorsed more severe depression symptom severity scores ( $M = 33.5, SD = 8.42$ ) than participants who identified as African American ( $M = 10.22, SD = 8.00, p < .05$ , Tukey HSD), Caucasian ( $M = 9.35, SD = 8.42, p < .01$ , Tukey HSD), Hispanic ( $M = 4.4, SD = 3.21, p < .05$ , Tukey HSD), and Other ( $M = 7.57, SD = 6.9, p < .01$ , Tukey HSD). Thus, this sample's lesbian sexual assault survivors who also identified as having a mixed ethnic background endorsed, on average, severe depressive symptom severity, whereas African American, Caucasian, Hispanic, and Other participants' mean depression scores fell in the range that is not indicative of depression.

Participants' demographic characteristics were explored by trauma category—those who survived ASA only, CSA only, and those who experienced both CSA and ASA. No significant differences were found between trauma groups based on age,  $F(2, 67) = .91, p > .05$ , or ethnicity,<sup>4</sup>  $\chi^2 = (6, N = 72) = .29, p > .05$ . Sexual trauma categories did differ, however, in IH,  $F(2, 62) = 4.44, p < .05$ , and PTSD symptom severity,  $F(2, 67) = 4.55, p < .05$ . As such, pairwise post hoc comparisons were computed using Tukey's HSD test for these variables. Psychological outcomes as a function of sexual trauma category are presented in Table 1.

**Table 1**  
Means and Standard Deviations for Symptom Severity  
as a Function of Trauma Type

Variable	CSA only ( <i>n</i> = 24)	ASA only ( <i>n</i> = 17)	CSA & ASA ( <i>n</i> = 33)
Depression	11.8 (14.19)	8.91 (9)	16.82 (11.65)
PTSD	17.83 (13.54)	6.82 (9.16) <sup>a</sup>	18.56 (12.7) <sup>a</sup>
Experiential avoidance	32.92 (11.07)	31.08 (9.77)	37.47 (7.40)
Internalized homophobia	1.87 (.77) <sup>ab</sup>	1.90 (.68) <sup>a</sup>	2.54 (.83) <sup>b</sup>

*Note.* Values enclosed in parentheses represent standard deviations. PTSD = posttraumatic stress disorder symptom severity as measured by the Posttraumatic Stress Diagnostic Scale. Depression = Depression symptom severity score as measured by the second version of the Beck Depression Inventory. Experiential avoidance severity was measured by Acceptance and Action Questionnaire. Internalized homophobia was measured by the overall score on the Lesbian Internalized Homophobia Scale. Means with the same subscripts differ at  $p \leq .05$ . ASA = adult sexual assault; CSA = child sexual abuse.

With respect to IH, the group that experienced both CSA and ASA endorsed significantly greater IH ( $M = 2.54$ ,  $SD = .83$ ) than the ASA-only group ( $M = 1.90$ ,  $SD = .68$ ,  $p < .05$ , Tukey HSD) and the CSA-only group ( $M = 1.87$ ,  $SD = .77$ ,  $p < .05$ , Tukey HSD). The latter two groups, however, did not differ significantly from one another. These results were unexpected, given that Gold et al. (2007) did not find any differences in IH based upon sexual assault category for gay men. Because the scale ranges from 1 to 7, with 7 indicating the most severe IH, these findings suggest that the sample was relatively low in IH. However, these results are similar to those found in other studies that have used the LIHS to measure IH in community samples (see Amadio, 2006 [ $M = 1.98$ ,  $SD = .69$ ] and Szymanski et al., 2001 [ $M = 1.89$ – $2.28$ ,  $SD = .61$ – $.80$ ]).

In addition to IH, the group that had experienced both CSA and ASA endorsed significantly greater PTSD symptom severity ( $M = 18.56$ ,  $SD = 12.70$ ) than the ASA-only group ( $M = 6.82$ ,  $SD = 9.16$ ,  $p < .05$ , Tukey HSD), but did not differ significantly from the CSA-only group ( $M = 17.83$ ,  $SD = 13.54$ ,  $p > .05$ , Tukey HSD). According to scoring guidelines for the PDS (Foa, 1995), both the CSA-only group and the combined CSA and ASA groups' mean scores fell in the moderate range for PTSD symptom severity. The ASA-only group's mean score, however, was suggestive of mild symptom severity.

No significant differences were found between trauma categories with respect to experiential avoidance,  $F(2, 68) = 2.23$ ,  $p > .05$ , or depressive symptom severity,  $F(2, 66) = 2.27$ ,  $p > .05$ . This sample reported relatively low levels of experiential avoidance ( $M = 33.35$ ,  $SD = 9.97$ ) in comparison with other studies. Marx and Sloan (2002) found the mean AAQ score to be 36.80 for undergraduate CSA survivors and 33.30 for nonvictims. Similarly, normative data have indicated a mean score of 38 for nonclinical popula-

**Table 2**  
*Psychological Outcome Correlations for Lesbian Sexual  
Assault Survivors*

Variable	Depression	PTSD	Avoidance	Mean	Alpha
Depression				11.67 (10.25)	.92
PTSD	.638 <sup>c</sup>			14.25 (13.15)	.89
Avoidance	.767 <sup>c</sup>	.549 <sup>c</sup>		32.43 (10.25)	.73
IH	.195	.261	.309	2.02 (0.79)	.93

*Note.* Values represent two-tailed Pearson correlations. Mean = mean score across the entire sample. Alphas = Cronbach's alpha. Values enclosed in parentheses represent standard deviations. PTSD = posttraumatic stress disorder symptom severity as measured by the Posttraumatic Stress Diagnostic Scale. Depression = depression symptom severity score as measured by the second version of the Beck Depression Inventory. Avoidance = experiential avoidance severity as measured by Acceptance and Action Questionnaire. IH = internalized homophobia as measured by the overall score on the Lesbian Internalized Homophobia Scale. Means with the same subscripts differ: <sup>a</sup> $p \leq .05$ . <sup>b</sup> $p \leq .01$ . <sup>c</sup> $p \leq .001$ .

tions and 42 for clinical populations (Hayes et al., 2004). In terms of depressive symptom severity, this sample's mean fell in the mild range ( $M = 11.99$ ,  $SD = 12.05$ ) and ranged from 0, which is indicative of faking good, to 60, which suggests severe depression.

#### *Correlates of IH and Experiential Avoidance*

To test the hypothesis that IH severity is related to psychological symptomatology among lesbian sexual assault survivors, two-tailed Pearson correlations were computed for IH, experiential avoidance, and PTSD and depressive symptom severity. Results are presented in Table 2. IH significantly correlated with PTSD symptom severity and experiential avoidance. Surprisingly, IH did not correlate with depressive symptom severity. Experiential avoidance correlated with both PTSD and depressive symptom severity.

#### *Mediation Analyses*

To test the hypothesis that experiential avoidance mediates the relation between IH and PTSD symptom severity, Baron and Kenny's (1986) criteria for mediation were followed (Baron & Kenny, 1986; Kenny, Kashy, & Bolger, 1998). Regression analysis indicated that IH significantly predicted experiential avoidance. In addition, IH predicted PTSD symptom severity. The proposed mediator, experiential avoidance, also predicted PTSD symptom severity. Multiple linear regression analyses indicated that, when experiential avoidance was included in the model, the relation between IH and PTSD was insignificant, thus indicating full mediation. Regression results are listed in Table 3. Due to a small sample size ( $n = 72$ ) and concerns regarding low statistical power, a bootstrapping approach (e.g., Preacher & Hayes, 2008) was used to test for the significance of these findings. Results showed that IH does have a significant indirect effect on PTSD symptom severity, with experiential

**Table 3**

Experiential Avoidance as a Mediator of the Relation between Internalized Homophobia and Posttraumatic Stress Disorder (PTSD) Symptom Severity Among Lesbian Sexual Assault Survivors

<i>Criteria</i>	<i>Predictors</i>	<i>B</i>	<i>SE (B)</i>	$\beta$	<i>R</i> <sup>2</sup>
Experiential avoidance	Internalized homophobia	3.96	.345	.31 <sup>b</sup>	.10
PTSD symptom severity	Internalized homophobia	4.26	2.05	.26 <sup>a</sup>	.07
PTSD symptom severity	Experiential avoidance	.72	.14	.55 <sup>c</sup>	.30
PTSD symptom severity	Experiential avoidance	.63	.15	.5 <sup>c</sup>	.29
	Internalized homophobia	1.56	1.9	.1	

<sup>a</sup> $p \leq .05$ . <sup>b</sup> $p \leq .01$ . <sup>c</sup> $p \leq .001$ .

avoidance carrying the influence of IH to the dependent variable. The relationship between IH and PTSD noticeably decreases after controlling for avoidance ( $c - c' = .047$ ). A 95% confidence interval generated in the bootstrapping analysis estimated the true indirect effect to be between .011 and .091. Because 0 is not included within this confidence interval, it can be concluded that the indirect effect differs from 0 at  $p < .05$ .

## DISCUSSION

The findings of this study enhance our understanding of the emotional experiences and reactions of lesbian sexual assault survivors. IH appears to be associated with PTSD symptom severity among lesbian sexual assault survivors and may be an important factor to consider in treating this population. Experiential avoidance fully mediated the relation between IH and PTSD symptom severity. Consistent with the emotion-processing theory of PTSD, it is possible that the cognitive processes that comprise IH, such as self-blame, are connected with fear, escape, and experiential avoidance. Research has consistently indicated that the avoidant behaviors and coping styles consistent with experiential avoidance (e.g., emotion suppression, substance abuse, dissociation) are associated with increased PTSD symptom severity (Gold et al., 2007; Marx & Sloan, 2002, 2005; Polusny et al., 2004). Thus, it is possible that IH affects PTSD symptom severity via the behaviors associated with experiential avoidance.

Based upon the cross-sectional nature of this study, however, the directionality of these findings remains unclear. It is possible, for example, that PTSD leads to both experiential avoidance and IH. There is significant overlap between experiential avoidance and the avoidance symp-

tom cluster of PTSD, which includes avoidance of trauma-related people, places, thoughts, and emotions; feeling distant from others; a loss of interest in previously enjoyable activities; and difficulty feeling positive emotions. As such, experiential avoidance could have followed, rather than preceded, the PTSD. Furthermore, the hypervigilance associated with PTSD leads to increased attention to anything that could be construed as threatening. PTSD, therefore, could increase lesbian survivors' sensitivities to and inculcation of homophobia, thus increasing their IH. Future research should explore these associations using a prospective design to gain a better understanding of the temporal relations among these variables.

Another limitation of this study is its reliance on retrospective self-reports, which allows for response and memory biases, particularly for CSA (Gold et al., 2007). In addition, the lack of corroboration for these events limits our ability to make strong claims about the relation between IH and sexual assault. IH could predispose lesbians to psychopathology, memory bias, and feeling traumatized in general. Prospective research that involves some sort of corroboration could improve our understanding of these variables.

The recruitment technique utilized in this study is another limitation, especially given the focus on IH. By recruiting from LGBT events and organizations, only individuals who were comfortable with disclosing their sexual orientations in public were included. The results, therefore, may not generalize to everyone who identifies as gay or lesbian or those who engage in same-sex sexual activity regardless of identification. In fact, individuals with the highest levels of IH were very unlikely to be included in this sample because they would be loath to attend LGBT events. Also, by recruiting at LGBT organizations, we may have created demand characteristics that artificially deflated IH scores. This recruitment style likely resulted in a restricted range of IH scores, which could explain the finding that IH was not correlated with depression symptom severity in our sample. Given that other researchers have consistently found an association between the two, it is likely that range restriction resulted in an underestimation of the associations among the variables we investigated. At the same time, it is important to note that our IH scores were similar to those in the extant IH research on community samples of lesbians. Future research, however, should use alternative recruitment techniques, such as random digit dialing in LGBT-populated cities and towns, Internet recruiting, and snowball sampling<sup>5</sup> in the exploration of IH because each of these methods allows for increased anonymity and would likely increase the sample's range of IH. In addition to potentially reducing IH in our sample, our community-based recruitment likely led to more limited psychopathology among participants. The overall levels of PTSD and depression symptom severity reported were relatively low in our sample. Future research should explore these hypotheses using clinical samples.



There are several clinical implications that can be drawn from these results. First, IH is an important construct for mental health providers to assess directly when treating lesbian sexual assault survivors. This assessment can be accomplished by using a standard self-report measure, such as the LIHS, or via a more general clinical interview. If the patient appears to have significant IH, it may be important to explore more specifically the connections that she makes between her assault history and her sexual orientation, particularly if they revolve around self-blame or feeling constantly vulnerable and unsafe. Furthermore, it may be important to assess for her sense of resilience or self-efficacy, as she may view her lesbianism as an intractable premorbid mental illness exacerbated by trauma sequelae, thus giving her a hopeless perspective on treatment. Cognitive processing therapy (CPT; Resick & Schnicke, 1993), a "gold standard" empirically supported treatment for PTSD, may be particularly helpful for lesbian survivors with IH. In addition to a written exposure component that helps the patient to habituate to her memories, fear, and emotion, this therapy dedicates a significant amount of time to dismantling patients' unhealthy thoughts and schemas that contribute to and maintain avoidant behaviors and PTSD (Resick & Schnicke, 1993). CPT would involve providing psychoeducation and Socratic questioning to dismantle these beliefs and thus provides a clear structure for confronting IH therapeutically. Although there have been no formal treatment studies regarding IH and CPT at this time, Kaysen, Lostutter, and Goines (2005) described a case study utilizing CPT to treat a gay man with IH who was physically attacked as an anti-gay assault. They found that this treatment led to both reduced acute stress disorder and depressive symptom severity at both the end of treatment and at 3-month follow-up.

Alternatively, the experiential avoidance findings in this study suggest that an acceptance-based therapy approach may be helpful for lesbian sexual assault survivors. These therapies involve encouraging clients to accept rather than avoid painful thoughts, memories, and emotions. Acceptance and commitment therapy (ACT; Hayes et al., 2004), for example, involves helping patients to understand the harmfulness of experiential avoidance and to develop more adaptive behavioral repertoires for confronting painful private events (Marx & Sloan, 2002; Walser & Hayes, 1998). ACT could, therefore, provide a structure for lesbian survivors to accept both their sexual orientation and sexual assault sequelae in a way that allows for experiential rather than avoidant responses to both.

In addition to helping the patient accept her sexual orientation as part of the therapeutic process, it is also important to consider the therapist's comfort with sexual minorities as well. Regardless of sexual orientation, the client-therapist alliance has been found to be a powerful predictor of outcome (Krupnick et al., 1996). In dealing with a topic as sensitive as IH, this relationship may be especially important. The therapist is likely to either

facilitate or hinder the dismantling of IH by modeling either comfort or discomfort with clients who are lesbian sexual assault survivors.

As the first and only study to explore the relations among IH, experiential avoidance, and sexual assault sequelae, several important areas of research remain untapped. First and foremost, these findings need replication and more rigorous examination in order to establish the robustness and directionality of the relations. In addition, the scope of this research should be expanded to include bisexual and transgender survivors, once appropriate IH measures are created for use with these populations (Gold et al., 2007).

Furthermore, it is important to examine how gender and ethnicity moderate these relations. Internalized racism has been associated with anxiety and depression (Tull et al., 1999; Watts-Jones, 2002) and psychological distress (Webster, Vogel, Wei, & McLain, 2006) among racial and ethnic minorities. Similarly, researchers have linked internalized sexism with poor body image (Forbes, Doroszewicz, Card, & Adams-Curtis, 2004), psychological distress (Szymanski & Kashubeck-West, 2008), and depression (Szymanski & Kashubeck-West, & Meyer, 2008) among women. Lesbian sexual assault survivors who are also ethnic minorities, therefore, could be coping with all three forms of internalized oppression. Perhaps multiple internalized oppressions contributed to our findings that lesbian survivors who identified their ethnicities as Mixed endorsed more severe depression symptom severity than participants from the other ethnic identities. Alternatively, IH itself is likely to differ across cultures, as cultural beliefs and stereotypes about what it means to be a lesbian vary across cultural and socioeconomic groups (Garnets & Kimmel, 1993). Future research, therefore, should explore all of these constructs, their unique contributions to recovery, and the best way to address them in therapy.

With respect to gender, it is noteworthy that these results both emulate and differ from those found in Gold et al.'s (2007) examination of gay male sexual assault survivors. In general, the relation between IH and psychological symptom severity was stronger among the male survivors than among the lesbian survivors despite similar recruitment techniques. One potential explanation for these differences is gender-based societal stigmatization regarding sexual assault. Since the 1970s, much attention has been focused on raising public awareness about the sexual assault of women and providing education about this societal problem (Davies, 2002). The sexual assault of males, however, has received little consideration and, as a result, antiquated myths and stereotypes have continued to be accepted. Many people believe either that a man cannot be raped or, if he is, the results are less severe because he must have wanted the experience (Davies, 2002). Gay male survivors with high IH may be more likely to associate their sexual assault histories with homophobic beliefs, such as "I deserved to be sexually assaulted because I am gay," because they are not provided with alternative explanations

by society at large (Garnets et al., 1990). Future research should attend to gender differences in factors that influence the recovery of sexual minorities who have experienced sexual assault.

Contextual factors specific to the sexual assault also merit additional consideration (Gold et al., 2007). Perhaps the relation between IH and psychological outcome differs among those who are sexually assaulted as hate crimes, those who experience date rapes, and those who survived CSA. Another contextual issue that was not examined here was the influence of the sexual perpetrator's gender and sexual orientation on the relation between IH and symptom severity (Gold et al., 2007). It is possible that being sexually assaulted by another sexual minority would be more relevant to the relation between IH and psychopathology than being assaulted by someone who is heterosexual. Further exploration of this area of research should pay more attention to sexual assault context.

Although this study has several limitations, we succeeded in exploring important and culturally relevant factors in an understudied population, namely lesbian sexual assault survivors. This is especially important in light of the fact that LGBT individuals utilize psychotherapy services at higher rates than the general population (Cochran, Sullivan, & Mayus, 2003); nearly all therapists report providing services to at least one LGBT client (Murphy, Rawlings, & Howe, 2002); and at least 30% of lesbians report experiencing CSA, ASA, or both (Balsam et al., 2005; Doll et al., 1992; Heidt et al., 2005). If the relations among IH, experiential avoidance, and PTSD symptom severity continue to receive support, it may become important to integrate the assessment and treatment of IH and/or experiential avoidance into evidence-based treatments and prevention efforts for trauma survivors (Gold et al., 2007). Given that LGBT individuals continue to face significant societal stigmatization (Meyer, 1995), it is important that both the research and clinical communities improve upon our abilities to identify IH, understand how it differs based on gender and cultural background, understand its influence on psychological adjustment, and effectively address this issue in therapy.

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## NOTES

1. The variability in sexual assault rates reported across studies is often due to inconsistencies in defining what constitutes sexual assault, methods of assessing it, and age ranges of the samples (Bolen & Scannapieco, 1999; Russell & Bolen, 2000).
2. The terms "homophobia" and "internalized homophobia" have received criticism because these concepts are not phobias in the clinical sense (Kitzinger, 1987; Shields & Harriman, 1984). More specifically, it has been noted that homophobic attitudes and behaviors do not necessarily come from a defensive, self-protective state, but rather the absorption of societal attitudes (Herek, 1996). As such, these terms are misleading in that they encourage a focus on the individual, rather than

cultural norms (Herek, 1996). Although these criticisms are well founded, the term internalized homophobia continues to predominate in the research and clinical literature (Szymanski & Chung, 2003). As such, this terminology will be used throughout this article to be consistent with the extant literature on this topic.

3. Two studies have attempted to provide empirical support for the notion that sexual assault causes homosexuality (Cameron & Cameron, 1995; Gundlach, 1977). Both of these studies are methodologically flawed in that they use correlational data to imply causation.
4. Cohen (2001) indicates that cell sizes need to be at least 5 for the chi square statistic to be accurate and recommends combining categories with small frequencies when this assumption is violated. Due to the small sample size, several of the ethnicity categories comprised fewer than 5 participants. For this reason, participants who identified as Asian, Hispanic, Native American, and Other were combined into one group. Unfortunately, this combination may have obscured important group differences.
5. Snowball sampling is a technique whereby existing participants recruit future participants from among their social networks. This technique is often used when studying populations that are difficult for researchers to access, such as sexual minorities (Salganik & Heckathorn, 2004).

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